SYRINGE EXCHANGE PROGRAM (SEP)

Certification Application

I. Applicant Organization Information

Organization Name:			Telephone Number: ( )		Date of Application *(mm/dd/yyyy):* / /
Proposed SEP Name *(if different from above):*					
Address *(Number, Street, Suite #):*	City:	County:		State:	ZIP Code:
Mailing Address *(if different from above):*	City:	County:		State:	ZIP Code:
Name of SEP Administrator:	Title:	Telephone Number: ( )	E-Mail Address:		

II. Services Applicant Currently Provides to Injection Drug Users (IDUs)* *(check all applicable boxes)*

Drug Abuse Treatment Services	☐ Directly	☐ Via Referral
HIV or Hepatitis Screening	☐ Directly	☐ Via Referral
Hepatitis A and Hepatitis B Vaccination	☐ Directly	☐ Via Referral
Screening for Sexually Transmitted Infections	☐ Directly	☐ Via Referral
Housing Services for the Homeless, Victims of Domestic Violence, or Other Similar Housing Services	☐ Directly	☐ Via Referral
Distribution of Condoms	☐ Directly	☐ Via Referral
Risk Reduction Education	☐ Directly	☐ Via Referral

* **IMPORTANT:** All services must be currently offered *(directly or via referral)* in order to apply for Certification.

III. Applicant Organization Description *(please briefly describe the organization's mission and core services)*

IV. Description and Summary of Proposed SEP

Program Service Delivery Mode *(check one)*: ☐ Fixed Site ☐ Mobile Site ☐ Both Fixed and Mobile Sites	Estimated Annual Number of Clients to be Served:	Estimated Annual Number of Syringes Dispensed & Collected: &

SEP Location(s), Days and Hours of Operation *(if more than three locations, provide all of the requested information below for each additional location in an attachment)*:

Name of Location	**Days and Hours of Operation** *(e.g. Monday - Friday 2pm to 8pm, Saturday 11am to 2pm)*
1:	
2:	
3:	

For each of the SEP locations above, please provide the contact name, phone number, and e-mail for the neighborhood association of the location *(if one exists)*:

Contact Name	**Phone Number**	**E-mail Address**
1:	( )	
2:	( )	
3:	( )	

For each of the SEP locations above, please describe the staffing *(please indicate number of staff, titles of positions, and a brief description of their duties)*:

	Number of Staff	**Title of Position(s)**	**Description of Duties**
1:	#		
2:	#		
3:	#		

Please provide a short summary paragraph that will be posted on the California Department of Public Health, Office of AIDS website, which summarizes the proposed program and includes the name of the applicant organization, the name of the SEP *(if different)*, the location(s), hours and days of service, and types of services to be delivered *(not to exceed 150 words)*:

V. Needs Statement

Please provide the rationale for the request for Certification in the location(s) specified and use data and other objective sources to document the need. Examples include statistics on HIV infection among IDUs in the local health jurisdiction (LHJ), statistics on viral hepatitis among IDUs in the LHJ, and the presence of IDUs in the location(s):

VI. Additional Required Information

Additional requirements for SEP Certification are listed in the California Code of Regulations Subchapter 15, Sections 7000 through 7016, Title 17, Division 1, Chapter 4.

Applicants must attach a copy of each of the following:

a) Syringe Dispensing Plan as described in Section 7012(a);
b) Syringe Collection and Disposal Plan as described in Section 7012(b);
c) Service Delivery Plan as described in Section 7012(c);
d) Data Collection and Program Evaluation Plan as described in Section 7022(d);
e) Community Relations Plan as described in Section 7022(e); and
f) A budget for the program which includes a minimum projected income and costs for personnel, outside services and operating expenses, including but not limited to rent, utilities, equipment, materials including syringes and disposal containers, transportation, insurance, training, meetings, syringe disposal services, and indirect costs.

A description of each plan can be found at: http://www.cdph.ca.gov/programs/aids/documents/SEPoperatingrequirements.pdf

VII. Applicant Acknowledgement and Attestation**

The following SEP services must be provided to all participants by State-certified SEPs per Health and Safety Code Section 121349(d)(3):

- Needle and syringe exchange services;
- HIV and viral hepatitis prevention education services; and
- Safe recovery and disposal of used syringes and sharps waste.

The Applicant attests that upon Certification it will comply with state laws, regulations, and local ordinances.

The Applicant also attests that it has the capacity to begin syringe exchange services within ninety (90) days of Certification.

The Applicant further acknowledges and agrees to the involvement of program participant input into program design, implementation, and evaluation.

Signature: _____ **Date** *(mm/dd/yyyy)*: _____

** **IMPORTANT:** Submission of an application does not constitute Certification.

Completed applications for Certification can be submitted via:

Mail:

California Department of Public Health, Office of AIDS
Attention: SEP Certification Program
P.O. Box 997426, MS 7700
Sacramento, CA 95899-7426

or:

E-Mail:

SEPCertificationProgram@cdph.ca.gov

Additional information on SEP Certification can be found at:

http://www.cdph.ca.gov/programs/aids/pages/SEPCertificationApplications.aspx